

TREATMENT PLAN AND PROGRESS REPORT

TREATMENT PLAN

A treatment plan must be submitted by the provider for each individual and service the provider provides for the Adult Head Injury Program participants. The treatment plan shall be developed with the input of the participant's planning and treatment team, which includes the Service Coordinator. The Service Coordinator serves as the central point of knowledge about the participant's functioning and needs, and shall assure that the provider's treatment plan matches the needs of the participant at the time of service.

A treatment plan must be submitted to the Service Coordinator each quarter upon the submission of a prior authorization for services. When a new participant is referred for services, the provider has 30 days from the first date of services authorized to complete and submit the treatment plan. Subsequent treatment plans must be submitted quarterly along with the request for authorization for continued services. The Service Coordinator may deny authorization of services if an acceptable treatment plan is not received from the provider.

Treatment plans are due to the Service Coordinator by the 10th of the month, prior to the quarterly dates of service. The following is a schedule of treatment plan and prior authorization due dates:

Quarterly Dates of Service	Prior Authorization Due Date	Treatment Plan Due Date
January – March	December 10	December 10
April – June	March 10	March 10
July-September	June 10	June 10
October – December	September 10	September 10

The treatment plan shall be provided in any format designed by the provider as long as minimum elements of information are included in the plan. The following are minimum elements of the treatment plan:

- Participant identification (name, dcn, etc.)
- Provider identification (name of provider agency, direct care worker contact information, etc.)
- Service dates (covers the time period of the authorization request)
- Identification of overall participant goals (independent living, community participation, and/or vocational/educational)
- Identification of specific participant goals to be worked on during the service dates requested (what are the barriers keeping the participant from independent living, community participation, and/or vocational/educational goals)
- Identification of specific activities/strategies/techniques planned for the service date period
- Identification of any anticipated obstacles/barriers in achieving the participant goals and strategies planned to overcome them

- Target date for expected completion of specific goals (expected duration of service to meet goals)

MONTHLY PROGRESS REPORTS

A progress report (after each month of service provided) must be submitted to the Service Coordinator by the 10th of the month following the month the services were received. The following is a schedule of progress note due dates:

Month of Service	Progress Note Due Date		Month of Service	Progress Note Due Date
January	February 10		July	August 10
February	March 10		August	September 10
March	April 10		September	October 10
April	May 10		October	November 10
May	June 10		November	December 10
June	July 10		December	January 10

The progress report is an update on the participant that communicates timely and relevant issues to the Service Coordinator. The Service Coordinator's knowledge of these issues is key to enabling the Service Coordinator to assist in the comprehensive service coordination needs of the participant. Significant changes in participant's status or identification or concerns for the participant should be reported immediately to the Service Coordinator without waiting for the submission of a progress report.

The following are minimum elements of the progress report:

- Participant identification (name, dcn, etc.)
- Provider identification (name of provider agency, direct care worker contact information, etc.)
- Reporting Month of Service
- Utilization of Services Authorized (Units Authorized, Units Used)
- Specific activities and strategies worked on during the month
- Overall progress toward participant goals and any goals completed during the month
- Any barriers (anticipated or unexpected) experienced
- Any linkages to other community resources or agencies
- Any changes in participant's status and/or natural supports (e.g., change in address, illness of participant/family member, etc.)
- Any concerns of the provider relevant to the participant (participant attitude, participation, attendance, etc.)

The above requirements for monthly progress notes apply for Transitional Home and Community Support Training, Pre-Vocational/Pre-Employment Training, Socialization Skills Training, Special Instruction, and Supported Employment/Follow Along services provided.

Clinical visit notes on Adjustment Counseling and Behavioral Assessment and Consultation services provided, may be submitted to the Service Coordinator on a monthly basis (or other time frame as approved by the Service Coordinator) in lieu of the monthly progress note. A clinical evaluation report of a neuropsychological examination must be submitted to the Service Coordinator following the examination.

The treatment plan and progress reports must be submitted typewritten or in legible handwriting. If submitted in handwriting that is not legible, the Service Coordinator may request a typewritten report. The Service Coordinator may request additional information from the provider if needed to consider continuation of the service.